

**GOVERNMENT OF ANDHRA PRADESH**  
**ABSTRACT**

Constitution of State Level RMNCH+A Steering Group, RMNCH+A Operations Group, and District Level RMNCH+A Group for intensification of efforts in High Priority Districts under Reproductive, Maternal, Newborn, Child Health & Adolescent Health (RMNCH+A) Approach in Andhra Pradesh – Orders – Issued

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**HEALTH, MEDICAL & FAMILY WELFARE (D1) DEPARTMENT**

**G.O.Ms.No.100**

**Dated:28-05-2014**

**Read:**

From the Joint Secretary (RCH), MOHFW, Government of India,  
Lr. No. 643/DC (CH&I)/2013, Dated 30/04/2013

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**ORDER:**

Improving maternal and child health is central to the achievement of national health goals under the National Rural Health Mission (NRHM). India has launched many flagship programmes on health and nutrition, which have led to improvement in the health of mothers and children and their survival, as reflected in the health indicators. However, the goal has not yet been fully achieved and requires combined effort of central and state government, civil society organizations, development partners and the private sector. Under 12<sup>th</sup> Five Year Plan, by 2017, India is committed to bring down the IMR to 25 per 1000 live births and MMR to 100, which also stands true for Andhra Pradesh (current IMR – 41 per 1000 live births and MMR – 110 per 100,000 live births). This requires intensification of the efforts and concerted focus in the districts that have poor health parameters.

2. In order to further accelerate the decline in maternal and child mortality and galvanize unified efforts of all stakeholders a 'Call to Action: For Every Child in India' summit was organized from 7-9 February 2013 in Mahabalipuram, Tamil Nadu. The summit was led by the Ministry of Health and Family Welfare with participation from Department of Women and Child Development, and diverse set of stakeholders including civil society, UN agencies, development partners, global experts, private sector and media.

3. A National Consultation was held on 10<sup>th</sup> April 2013 in which the lead development agencies working across the states agreed to '**harmonize**' the efforts of all development partners working in the high priority districts and provide technical assistance across the entire spectrum of RMNCH+A (Reproductive, Maternal, Newborn, Child and Adolescent Health), and assist the State governments in achievement of desired health outcomes. UNICEF is identified as the lead development partner in AP, which will be supported by other development partners in the state such as Earth Institute, Public Health Foundation of India (PHFI), Centre for Disease Control & Prevention (CDC), NICE Foundation, CHAI and others.

4. Based on select MCH indicators, a composite index is developed. Based on this index, a relative ranking of districts has been done within each state. From this ranking, the bottom 25% of the districts have been selected as 'High Priority Districts' (HPDs). Left Wing Extremism (LWE) affected and tribal districts falling in the bottom 50 percent are also included in the list. Based on these criteria, a total of 184 HPDs have been selected across 29 states in the country. The six High Priority Districts in the state of Andhra Pradesh are *Adilabad, Mahabubnagar, Kadapa, Kurnool, Visakhapatnam, and Vizianagaram*.

**P.T.O.**

5. In order to implement the new RMNCH+A in the state of Andhra Pradesh, the following institutional structures are created at state and district level.

**State Level:** At the state level, there will be RMNCH+A Steering group and RMNCH+A Operations group. The structure, composition and role of these groups are described below.

**A. State level RMNCH+A Steering Group:** The State level RMNCH+A Steering Group will comprise of –

1. Principal Secretary, HMFW
2. Principal Secretary, WCD
3. Principal Secretary, RD
4. Commissioner, HFW
5. Commissioner Tribal Welfare
6. Project Director, APSACS
7. Commissioner, WCD
8. CEO, SERP
9. Mission Director, NRHM
10. Director Public Health
11. Commissioner APVVP
12. Programme Nodal Officers
13. Health Specialist, UNICEF
14. Representative of Earth Institute, Columbia University
15. Representative of PHFI/Indian Institute of Public Health – Hyderabad
16. Representative of Centre for Disease Control & Prevention (CDC)
17. Representative of IAP/FOGSI

- The RMNCH+A Steering Group will be the highest body to ensure implementation of various RMNCH+A interventions in the state of AP. It will be chaired by the Principal Secretary, HMFW and will meet monthly for the first three months, followed by quarterly meetings thereafter. The group will provide guidance to the operations group and will be responsible for convergence of various departments and their participation. The Steering Group will review progress of planning and implementation of various RMNCH+A interventions in HPDs using dashboard and scorecards. They will ensure that HPDs get timely support from the state to implement the critical interventions, through policy and administrative decisions such as those for HR, budget allocations etc. It will serve as a resource group to solve implementation bottlenecks and also to provide guidance from time to time to RMNCH+A Operations Group.

**B. State Level RMNCH+A Operations Group** - The State level RMNCH+A Operations Group will comprise of –

1. Commissioner, HFW (Chair)
2. Mission Director, NRHM (Convener)
3. Commissioner, APVVP
4. Commissioner, WCD
5. CEO, SERP
6. Joint Director, CHI
7. Joint Director, MNH
8. Joint Director, Training
9. Joint Director, Family Planning
10. Joint Director, IEC
11. Special Officers, SPMU NRHM
12. Special Officer, APVVP
13. Deputy Director, Demography
14. Chief Administrative Officer, NRHM

15. Chief Finance Officer, NRHM
16. Joint Director, Basic Services, APSACS
17. Secretary, IIHFW
18. Health Specialist, UNICEF Hyderabad
19. Representative of Earth Institute, Columbia University
20. Representative of PHFI/Indian Institute of Public Health – Hyderabad
21. Representative of Centre for Disease Control & Prevention (CDC)
22. Representative of IAP/NNF/FOGSI

- The RMNCH+A Operations Group will work under the overall guidance of RMNCH+A Steering Group. It will be chaired by CHFW and will meet every month, wherein they will review the progress through analysis of cluster score-cards, dash board and other relevant indicators. The group will conduct monthly review with the District Collectors and the District Level RMNCH+A Group through Video Conference. They will facilitate mapping, bottleneck analysis and data validation by District RMNCH+A teams in all HPDs and will also be responsible for preparing monthly report and submit to steering Group and Government of India.
- A team comprising of Additional/Joint Director from Directorate of Health, Special Officers - NRHM & APVVP and District Monitor from Development Partners will constitute RMNCH+A Unified Response Team (URT) for every HPD. This team will be responsible for implementing RMNCH+A activities in collaboration with District Health team and provide the necessary technical support to the HPDs. This team will report to the RMNCH Operations Group from time to time.

**District Level RMNCH+A Group:** The District RMNCH+A Group will comprise of

1. District Collector (Chair)
2. Project Director, DRDA
3. DM&HO (Convener)
4. Additional DM&HO
5. DIO
6. Project Director ICDS
7. DCHS
8. PODTT
9. DEMO
10. DPMU staff
11. SPHOs
12. Zilla Samakhya President (SERP)
13. District Monitors (RMNCH+A)
14. District Nodal Officers (*Maarpu*)
15. Faculty from Medical Colleges
16. IAP/FOGSI/IMA

- The District Level RMNCH+A Group will facilitate rapid assessment of the current status in HPDs, resource mapping, bottlenecks in service delivery mechanism and identify ways to address them with support from State level RMNCH+A Operations Group. It will be chaired by the District Collector, and will meet monthly. This meeting shall be integrated with District Monthly Program Review meeting and there should be an agenda item on RMNCH+A. The District RMNCH+A monitors will be specially invited for this meeting, who will present analyzed reports and monitoring data using standard templates. The process indicators (e.g. HR recruitment, training facility strengthening, supplies etc.) reporting the progress will also be presented in this meeting so that the gaps can be addressed by the District Level RMNCH+A Group and / or escalated to the state for necessary action and support as needed.

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- The minutes of the meeting with action points should be prepared and sent to the State Level RMNCH+A Operations Group to update on the progress made.
- 1. The Commissioner of Health & Family Welfare, Mission Director NRHM, Director of Public Health and Family Welfare, Commissioner of APVVP, the District Collectors, State Programme Officers and Development Partners shall take necessary action accordingly.
- 2. In order to operationalize the process of convergence through 'RMNCH+A' and actively engage all the stakeholders in the process, the District Collectors are requested to convene district level workshops and disseminate the objectives and the key interventions in RMNCH+A Approach.
- 3. The operational guidelines are annexed to this order.
- 4. This order is issued in consultation with Women Development and Child Welfare, Panchayat Raj and Rural Development and Tribal Welfare Departments.

**(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDHRA PRADESH)**

**AJAY SAWHNEY  
PRINCIPAL SECRETARY TO GOVERNMENT**

To

The Commissioner, Health & Family Welfare, AP, Hyderabad.  
The Mission Director, NRHM, AP, Hyderabad  
The Principal Secretary, WD & CW Dept., AP Secretariat  
The Principal Secretary, PR & RD Dept., AP Secretariat  
The Principal Secretary, Tribal Welfare Dept., AP Secretariat  
The Chief Engineer, RWS, AP, Hyderabad.  
The Commissioner, Rural Development, AP, Hyderabad.  
The Commissioner of Tribal Welfare, AP, Hyderabad.  
The Director of Public Health and Family Welfare, AP, Hyderabad.  
The Commissioner of AP Vaidya Vidhan Parishad, Hyderabad.  
All District Collectors and District Magistrates  
All District Medical and Health Officers  
All Regional Directors, Medical & Health Services in the State  
All Regional Directors, WD & CD Agency  
All District Coordinators of Health Services of APVVP  
All Superintendents of Area and District Hospitals  
Chief of Field Office, UNICEF Hyderabad

**Copy to:-**

P.S. to Advisor to Governor of Andhra Pradesh.

**// Forwarded by Order //**

**SECTION OFFICER**

**Indicators for dashboard monitoring system are based on life cycle approach:**

- District scores can be determined on the basis of the state average:
  - Positive scores from 1 to 4 for those above the state average (for positive indicators) and for those below the state average (for negative indicators).
  - Negative scores -1 to -4 for those below state average (for positive indicators) and for those above state average (for negative indicators).
  - Inconsistent data is deleted from the score sheet and districts given negative score for the indicator
- Scores for each district are consolidated as state score (all indicators have the same weightage)
- District performance can be classified into four categories based on the state scores (based on four quartiles)
- The quarterly dashboard monitoring system at state level will be compiled in the month following the quarter. State and districts should 'commit' their HMIS data within three weeks following a quarter.
- Steps are underway to include in HMIS the proportion of:
  - Pregnant women <19 years old to total women registered for ANC
  - Home Based New born Care (HBNC) visit by ASHA to planned visits
  - Children 9-11 months fully immunized to children 9-11 months due for immunization
  - Children with Diarrhoea who were treated with ORS to children reported with Diarrhoea
  - Children with Diarrhoea who were treated with ORS and Zinc to children reported with Diarrhoea
  - Children discharged live from SNCUs to number of admissions in SNCUs
  - Children with ARI who received treatment to children reported with ARI

**i) Prioritizing the action in the health sector:** The State is prioritizing following action in these districts.

**a) District Assessment:** Epidemiologic, demographic, socio economic and geographic profile of the district will be carefully assessed using a District Level Checklist. Detailed assessment of each district in terms of equity and access to health services and key social determinants of health will be done with 'difficult to reach' or 'inaccessible' areas clearly identified. The vulnerable and marginalized populations in the district will be identified along with the clusters and villages/hamlets where these populations reside. The remoteness of the village and accessibility to basic health services, including maternal and child health services will also be assessed.

**b) Assessment of local health system:** Mapping of the health infrastructure (SC, PHC, CHC, AH, DH), manpower (medical officers, specialists, staff nurses, ANMs, ASHAs), training facilities (ANM/GNM training schools, district training centre), and assessing the functionality of health facilities (IPD, OPD, minor & major surgeries, delivery points, FRUs conducting C section, 24x7 PHCs, newborn care facilities) will be undertaken as the first step.

**c) Differential Health Systems Planning for HPD**

**Financial allocations:** The state will allocate 30% higher resource envelope per capita for each HPD within the overall State Resource Envelope under NRHM. This will be specified and earmarked as a part of the ROP. In case of failure to utilize these funds in the specified districts, it will lose this unspent money.

**Relaxation of norms:** This is allowed for tribal areas under NRHM. Similar relaxation of norms is extended to all HPDs.

1. **ASHA recruitment:** The general norm of 'one ASHA per 1000 population' is relaxed in HPDs; for example, there should be one ASHA per habitation, in remote and inaccessible areas.
2. **Health Infrastructure as per IPHS norms:** Population norms for establishment of sub-centre should be relaxed; for example, it should be based on 'time to care' norm.
3. **Improving infrastructure in health facilities:**
  - a. Up-gradation of Sub centers: A full-fledged village health team should be located at the SC to address the basic health needs for the local population.
  - b. Construction of new PHC buildings: Construction of new buildings is proposed for 83 PHCs in the state, of which 28 PHCs are located in 6 HPDs.
  - c. Up-gradation of PHCs into CHCs: Identified PHCs will be upgraded into CHCs.

**Mobile Medical Units:** Till the time SC or PHC are established, underserved areas should be reached through MMUs. The HPDs are allowed to have more MMUs than other districts.

**Performance based incentives:** Special incentives to medical and para-medical staff for performing duties in difficult areas (e.g. identified health facilities; facilities remote from District Headquarters) shall be incorporated with appropriate financial and non-financial incentive schemes. The qualified human resource will work in HPDs with time-bound targets and performance benchmarks for addressing the key issues and optimum utilization of funds to ensure effective implementation of NRHM.

**ii) Priority interventions across RMNCH+A:** The priority interventions across RMNCH+A include the following:

- a. Antenatal care package; tracking of high risk pregnancies
- b. Maternal nutrition coupled with intake of IFA and iodized salt
- c. Strengthening of delivery points in terms of infrastructure, manpower, equipment and supplies
- d. Implementation of JSSK and JSY
- e. Thematic counseling with focus on breastfeeding and new born care
- f. NBCC at all delivery points including initiation of breastfeeding within first hour of birth
- g. Baby Friendly Health facilities
- h. Initiation of home visits to newborns (HBNC scheme)
- i. Intensification of Routine Immunization
- j. ORS and Zinc use in diarrhea; antibiotics for ARI
- k. Establishment and operationalization of NRCs and community based program for management of SAM
- l. Roll out of National Iron Plus Initiative covering all women in the reproductive age group, adolescents, pregnant and lactating women, and children (6-60 months; 6-10 years)
- m. Prioritization of training of ANMs, SNs for Skilled Birth Attendance, NSSK, IMNCI, IUCD insertion
- n. Doorstep delivery of contraceptives by ASHAs

**Contd....**

**iii. Special strategies, incentives, packages, schemes for HPDs**

- a. **Cash assistance for home delivery by SBA:** Pregnant women, who are 19 years of age and above and prefer to deliver at home in presence of SBA, should be given suitable incentives. The disbursement of such assistance is to be carried out at the time of delivery or around seven days before the delivery by an ANM/ASHA/any other link worker. The SBA can also be provided incentive to conduct home deliveries in selected villages /areas due to reasons of inaccessibility, remoteness, and security risks. However the list of villages or hamlets where home delivery by skilled birth attendant can be promoted should be pre-identified and notified by the district.
- b. **Accrediting private health institutions:** In order to increase the access to delivery care institutions, functioning private institutions that meet the criteria set out by GOI, should be accredited to provide delivery services, abortion care and newborn care. The district authorities should draw up a list of criteria/protocols for such accreditation; which will be inspected by team from State Medical Colleges. These institutions will be reimbursed for the health facilities provided to local population on pre-agreed rates.
- c. **Equipping Sub-centers for normal delivery:** A well-equipped Sub Centre should be established and made operational in tribal and hilly areas, since women living in such areas find it difficult to access a PHC/CHC for maternal care or delivery.

**iv. Improving demand for services**

- a. **Community outreach:** In addition to creating awareness on health issues and on social determinants of health, passing on information about available health services to the community is crucial for frontline workers and social mobilizers. The local population may not recognize the need for health services or there may be lack of trust in service providers or even the allopathic system of medicine. Due emphasis should be given to platforms like NHD which brings both information and services to the villages.
- b. **Social & Behavior Change Communication (SBCC):** The evidence based comprehensive Social & Behavior Change Communication (SBCC) strategy iterated in *Amma Kongu* will be used. A set of branded prototypes for posters, leaflets, press campaign and flip books have also been developed covering all issues under RMNCH+A as well as *Maarpu* which will be used for HPDs. These pre-tested branded materials will provide consistency in messages and characters, thereby leading to higher recall and impact among the audience. Additionally, the IPC films will be used for group IPC in SHG meetings and VHNDs.
- c. **Training:** The IPC and facilitation skills building training module on RMNCH+A issues developed under *Maarpu* will be used for training of ASHAs and MPHEOs. The trained Health Educators should act as Resource Persons in the districts and *Mandals*. In order to boost the motivation of the frontline functionaries, a state level press campaign will also be rolled out by NRHM.
- d. **Involve NGOs for community mobilization, service delivery:** If public sector has a limitation, NGOs should be involved to make the information and services more accessible to the underserved and vulnerable population.

**v. Multi-sectoral planning:** Health of the population cannot be improved in isolation; other services like transport, telephone/mobile connectivity, water, sanitation, girls' education and nutrition services are required to bring about desired results. In addition, convergence with other departments will promote better resource utilization.

**Monitoring & Reporting:** Facility based tracking should be the focus in the districts where facility based reporting has already been initiated. HMIS based dashboard monitoring system and District Score cards will provide a snapshot of progress made in the district and also to compare changes over the time. Regularity of monthly review meetings should be ensured by DM&HO/District Collector. A comparative assessment of district performance should be done in terms of service delivery on a quarterly basis. To ensure uniformity in the reporting, a common reporting/monitoring format will be developed and used. This data would be collected, collated and analyzed by UNICEF at the state level and shared with the districts and state for necessary actions.

**AJAY SAWHNEY**  
**PRINCIPAL SECRETARY TO GOVERNMENT**